Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED A KHALIFA MD PA
1415 Hwy 6, Suite 400-D
Sugarland TX 77478

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Number 54

MFDR Tracking Number
M4-12-3308-01

MFDR Date Received
July 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the request for reconsideration letter: "…The rational [sic] for the denial was 'per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure. The rational [sic] for the denial is totally vague…"

Amount in Dispute: $889.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…The basis of the denial is that the Physician CCI Edits V18.2 for 2012 indicate codes 95903 and 95904 are not separately reportable from code 95861 unless the appropriate modifier is used…Review of the requestor's bill shows no usage of any modifier indicating the two codes are separate from the EMG, code 95861. For this reason no further payment is due for these codes. However, Texas Mutual will reimburse the second unit of code 95934."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2012	95903 and 95904	$ 889.88	$0.00
	95934: The respondent's position statement states, "Texas Mutual will reimburse the second unit of code 95934". Requestor acknowledges receipt of this payment.		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for

resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 435 – per NCCI edits, the value of this procedure is included in the value of the comprehensive procedure
   - 193 – original payment decision is being maintained
   - 724 – no additional payment after reconsideration

Issues

1. Are the disputed codes separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Review of the CCI public files, along with the medical bill provided by the requestor finds that CPT codes 95903 and 95904 are component procedures of another service (95861) billed on the same day. For that reason, 95903 and 95904 are not separately payable. The use of an appropriate modifier may be allowed. A review of the submitted bill does not support that any modifier was appended to CPT codes 95903 or 95904.
2. The requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.